Clark County Children's Mental Health Initiative
Clark County, Washington
March 20–22, 2002

I. Background

A. Details of the Site Visit

The second system-of-care assessment of the Clark County Children's Mental Health Initiative (CMHI) took place on March 20–22, 2002. A team of two ORC Macro site visitors conducted a total of 23 interviews with representatives of the system of care, including the project director, members of the governance council, representatives of public child-serving agencies, family advocates, direct service providers, staff responsible for grant evaluation and quality review, and caregivers whose children and families have been served by CMHI.

Site visitors also reviewed randomly selected case records of children enrolled in the CMHI program. The case records provided additional information regarding program development and adherence to system-of-care principles.

The following report is based on information obtained from the system participant interviews, case record reviews, and additional documentation provided by grant community staff. The report is organized into five sections:

< Background of the project
< A description of the system of care at the infrastructure level
< A description of the system of care at the service delivery level
< System of care strengths and challenges
< Sustainability efforts and lessons learned

B. History and Background

As a result of legislation passed in 1989, responsibility and accountability for mental health services in Washington State shifted from the State level to county-based entities called Regional Support Networks (RSNs). The RSNs administer the State mental health funds to provide mental health services for individuals receiving Medicaid and others with low incomes. In southwest Washington, the Clark County RSN administers the mental health dollars and contracts with community mental health providers under the auspices of the Clark County Department of Community Services (DCS). In addition to mental health services, the Clark County DCS oversees drug and alcohol treatment and prevention, services for individuals with developmental disability, housing, community action programs, and youth and family services.

In 1995, Washington State was granted a 1915(b)(1) Medicaid waiver to enroll Medicaid recipients in Prepaid Health Plans (PHPs), in effect replacing the previous fee-for-service program with a

managed care system. The Clark County RSN entered into a full risk, outpatient mental health services contract with the State as a PHP. In 1996, the Clark County RSN selected United Behavioral Health (UBH) a subsidiary of United Health Care, to serve as an Administrative Services Organization to administer the PHP on the State's behalf. The contract with UBH expired in June 2001. The Clark County RSN determined that it had gained sufficient knowledge and expertise to assume administrative responsibility for managed care effective July 1, 2001.

In April 1998, the Clark County DCS applied to the Federal Center for Mental Health Services (CMHS) for a grant to fund enhancements to its existing system of care, to further develop a comprehensive, integrated system of care for children with severe emotional disturbance. Emphasis was placed on infrastructure development and implementation of the concepts of Individualized and Tailored Care (ITC) and the "wraparound" approach to service delivery. The grant application was approved for a period of 5 years, effective September 1998. In compliance with grant requirements, the Regional Research Institute for Human Services at Portland State University (PSU) was designated as the external evaluator over the life of the grant.

Now beginning its fourth year as a CMHS grantee, the Clark County CMHI continues to support the vision of building and sustaining a community of care for children and families. Legislation was passed in March 2002 to establish demonstration sites for statewide implementation of the children's system of care. Known as the *Engrossed Substitute House Bill 2574*, the legislation supports the following CMHI 2001 strategic goals:

< *Consumer/Family Voice/Partnership.* To fully and directly involve families representing target populations and communities as full partners in all levels of planning and implementation of service organization, management, and delivery.

< *Community Investment/Ownership.* To fully and directly involve community residents and indigenous community agencies and organizations as collaborative partners in the design and implementation of locally organized systems of care for specific neighborhoods, including all levels of planning, operations, and service delivery.

< *Infrastructure Development.* To design, implement and refine inter-systemic mechanisms to ensure the participation of families, youth, public planners, and child-serving systems in the planning, prioritization, service delivery, financing, and evaluation processes of the system of care.

< *Interagency Collaboration.* To promote and develop models and mechanisms for the effective integration of financing, policy, authority, and resources of child-serving systems to support system-of-care objectives for target populations of children and families at risk.

< *Individualized Care.* To assure the design, implementation, and coordination of individualized treatment plans with the goal of "One Child–One Plan."

- *Cultural Competence.* To assure the design, development, and implementation of culturally sensitive and competent services and business management processes in the context of the specific diversity represented by the target population and community.

- *Accountability.* To measure progress on goals and objectives and to collect data to support system reform.

Cultivating a culture of system reform at the service delivery level, while continuing enhancements to the system-of-care infrastructure, has been a significant objective of the DCS in the past year. Through the creation of "wraparound" service delivery partnerships with juvenile justice, the schools, and child welfare (see Section II.C., Service Array, for greater description of these efforts), the promotion of system-of-care principles within day-to-day children's mental health practice is beginning to occur.

Catchment Area and Target Population

The catchment area for CMHI is all of Clark County, located in southwestern Washington along the Columbia River and bordering Oregon. The population is approximately 387,000, with 60,000 (15.5 percent) covered by Medicaid. While the minority population documented by the 2000 census is less than 10 percent, that figure does not include approximately 20,000 Russian and other Eastern European immigrants who are classified as Caucasian. Seventy-nine percent of the children served during the first 3 years of the grant have been Caucasian.

CMHI targets children and adolescents and their families who have severe emotional disturbance and those who are at risk for developing a severe emotional disturbance.

Funding

Clark County's CMHI funding flows from several Federal, State, and local sources. For the current fiscal year (September 1, 2001–August 31, 2002), funding from CMHS is $1,467,051, not including a carryover of $892,996 from the prior year.

Pooled funding includes $700,000 from the Clark County Juvenile Department; $621,000 from child welfare, and $300,000 from Medicaid.

Other contributions during the last year include the following:

United Way	$500	Evergreen School District	$218,748
Robert Fizzell	$1,760	Clark County RSN	$134,442
Child and Family Services (in-kind)	$55,856	Juvenile Justice	$400,000
Southwest WA Health District	$37,514	Clark County Tax	$300,000
Community Choice	$1,180	Youth/Family	$200,000

Managed Care

Washington's Medicaid program operates as a managed care model under a Federal 1915(b)(1) waiver. The system is a "prepaid" comprehensive system of medical and health care delivery provided through a designated health care plan under contract with the State's Medical Assistance Administration. Mental health, substance abuse, and developmental disabilities services for Medicaid recipients are carved out of this waiver. In Clark County, these benefits are arranged through the Clark County Regional Support Network (RSN), which has the contract as the State's Prepaid Health Plan. The county also is responsible for providing or arranging mental health care for residents who are not covered by Medicaid but who otherwise meet CMHI's eligibility criteria. The mission of the Clark County RSN is to promote mental health and to ensure that residents of the Clark County region who experience mental illness during their lifetime receive treatment and services so that they can recover; achieve their personal goals; and live, work, and participate in their community. The Clark County RSN is now in its fifth year of operation as a prepaid health plan.

With respect to CMHI, the Clark County RSN recognizes that it cannot be insular—that managed care and the concepts of systems of care are not mutually exclusive, especially in relation to keeping children out of expensive, more restrictive settings. The RSN sees its role, therefore, as assessing the effects of managed care in relation to the quality of care delivered to children and their families. Performance-based contracting with mental health providers has been developed as a result. Providers are incentivized for improvements in family satisfaction, demonstration of the system-of-care principles, and performance on the various child outcomes measures. Providers also are expected to demonstrate that 60 percent of mental health services have been provided in the community versus the clinic setting and that alternative therapies such as art therapy, camps, mentoring, and parent partnering should be reimbursed.

II. Description of the System of Care at the Infrastructure Level

A. Governance

The Clark County system-of-care governance structure is known as the System of Care Policy Council. Its mission is to build and sustain an effective system of care in Clark County within four distinct domains: resources, structure, process, and community. The System of Care Policy Council is a two-tiered structure comprised of a Board of Trustees and a Board of Directors, each with different representatives and different functions, as described below. Overall the structure is comprehensive, with broad-based representation from all segments of the mental health service delivery continuum for children with severe emotional disturbance and their families.

Board of Trustees. The Board of Trustees consists of eight members, including four senior executives from public child-serving agencies: the Division of Children and Family Services (DCFS), Clark County Juvenile Court, the Department of Community Services, and a school district. The other four are a county commissioner (added since last assessment), a representative from the Association for Retarded Citizens (ARC) of Clark County, and two family representatives. The

Board of Trustees is a policy development body and acts on recommendations passed to it by the Board of Directors.

Board of Directors. The Board of Directors is a systems planning body. It currently has 14 members, of whom 8 are parents of children with serious emotional disturbance. Subcommittees include Finance, Family Services, Management Services, Membership, Elections, and By-Laws. There is family representation on all subcommittees.

Both boards meet monthly at midday, separately and then together. The full System of Care Policy Council meets from 5:30–7:30 on the first Thursday of each month. Food and childcare are provided. Most resolutions of the bodies are made by consensus and not by vote.

Changes in the governance structure are in process. The goal is to eliminate confusion about the roles of the two bodies by creating a new, simplified entity with stronger family participation and voice. The By-Laws Committee has been meeting for the past 6 months to revise by-laws for a single, merged board. The new structure will be referred to as the Community of Care Advisory Council. It will replace the System of Care Policy Council and have a 17-member board with four strong parents who are in the system, as well as professionals who have families in the system. Two subcommittees are proposed. One is for finance and the other, the Family Services Committee, will develop mechanisms that will ensure family voice.

B. Management and Operations

The Clark County RSN, under the direction of the Department of Community Services, continues to have responsibility for the day-to-day administration of CMHI. This responsibility includes staff support to the System of Care Policy Council, oversight of grant-funded staff and mental health contractors, and a new oversight role with management of the Children's Flexible Trust Fund, currently amounting to $200,000 annually. The Children's Flexible Trust Fund is a discretionary fund to be used for individualized needs of CMHI children and their families. Policies and procedures for accessing these funds were developed by the Board of Directors' Finance Committee and have been operational since August 2001. Since that time, $13,000 has been used to support 35 children and their families in the CMHI program.

Efforts to enhance procedures that support direct service delivery have improved over the past 18 months. Family and youth involvement in operational activities has been substantial. Activities include coordinating and providing training, recruiting and hiring staff, interviewing and data collection, and analyzing data for quality monitoring/evaluation functions. Staff training, especially in the areas of family-focused care and cultural competence, has also occurred.

Staffing Structure

Grant-funded positions for CMHI include the following:

Director, DCS	Administrative assistant
Assistant director, DCS	Special projects manager

Executive director, CMHI
Family support specialists (5)
Management analysts (2)
Family resource specialist
Care coordinator supervisor (IV–E Project)
Family information specialist
Mental health disability liaison
Finance manager
Care coordinators (2)

The grant also partially funds 16 staff positions through a partnership with the Clark County Juvenile Court and 11 staff positions within Catholic Community Services, the new Crisis Stabilization provider. (See the beginning of Section III for a description of these programs.)

Minority staff representation has increased significantly since the first assessment in September 2000 and now includes Russian, Hispanic, Laotian, Cambodian, African-American, and Native American individuals, some of whom are bilingual.

Training

CMHI has continued to offer many training activities on topics such as family-focused care, cultural competence, individualized care, consultation, and community activation. Training sessions have been available for families and child-serving agencies. When training programs are scheduled, grant staff request that professionals bring along family members, and families ask the professionals with whom they work to participate. This is done in order to ensure the uniform sharing of system-of-care messages. The school system is most noticeably absent from participation in CMHI training offerings.

C. Service Array

All grant-required services[1] are present in the CMHI service array. Additional services include residential treatment, inpatient hospitalization, mentoring, transportation, drug and alcohol counseling, and parent advocacy. Concerns were expressed about the adequacy of respite care and therapeutic foster care services.

At the time of the first system-of-care assessment, children and families had access to three historic mental health service providers: Columbia River Mental Health, the Children's Home Society, and the Children's Center. As a part of the children's mental health redesign in Clark County, several new mental health provider contracts were signed to expand capacity for crisis stabilization and more coordinated, flexible, and intense case management services. These new providers are described below:

< *Peace Health Behavioral Healthcare* provides child and adolescent Mobile Crisis and Assignment Teams, commonly referred to as MCAT, to provide 24-hour crisis intervention and outreach for children under age 18 and their families. This agency must respond to crisis

[1]Services required in the grant's guidance for applicants include diagnosis and evaluation; case management; outpatient individual, group, and family counseling; medication management; professional consultation; 24-hour emergency; intensive home-based; intensive day treatment; respite; therapeutic foster care; and transition-to-adult.

calls either by telephone or through an on-site visit, within 1 hour of receiving the call. Crisis stabilization may occur for up to 14 days.

< *(Catholic Community Services Family Preservation (CCS))* is a nonprofit program providing crisis stabilization and wraparound services to children and adolescents who have a wide range of mental health issues. Staff are available 24 hours per day, 7 days per week. Preauthorization is required for these services.

< *Institute for Family Development* provides individualized in-home counseling. Therapists are available 24 hours per day, 7 days per week.

< *Family Solutions* provides assistance with foster care and adoption.

In addition to the above list of providers, several other new supports for children and families have been added to the array. Family Resource Centers have been created to offer families education, social opportunities, and access to community-based supports. Services offered may include childcare, health service, early childhood education, parent education, recreational programs, and workforce development. There are currently seven Family Resource Centers operating in Clark County.

Support services for youth also have been added to the service array. In the spring of 2001, DCS leased an historic house from the Children's Home Society to serve as the Clark County Youth House. The Youth House is designed to provide a physical space for youth and youth-driven organizations, for the purpose of supporting youth empowerment and youth and adult partnerships.

D. Quality Monitoring

The Regional Research Institute for Human Services at Portland State University (PSU) continues to contract with the State for services relating to the CMHS national evaluation. PSU gathers and analyzes data obtained from agencies and providers, conducts focus groups, and administers interviews with caregivers and children. Findings are presented quarterly, and outcomes data, when available, are utilized to improve service delivery. Satisfaction surveys also are used as a barometer to inform program administrators of program effectiveness.

III. Description of the System of Care at the Service Delivery Level

Since the time of the system-of-care assessment in 2000, there has been a fundamental redesign of the way mental health services and supports are planned and provided for children. While the focus continues to be placed on a "wraparound" approach, the triage process is now intensity based and ensures that all children in need of mental health services can access them. Access in service planning and provision has improved considerably as a result of this approach.

The description of the system of care at the point of entry and the service planning and service delivery levels is based upon a review of two key CMHI system components. The first is the level

of intensity assigned to the child at the time of referral and intake into CMHI and is dictated by whether the child is in crisis or not. The second is the type of wraparound project the child is assigned to. Each of these elements is discussed below.

Assignment of Intensity Levels

There are essentially three levels of mental health care services within the CMHI: universal, targeted, and intensive.

Universal mental health services are defined as services that are brief to moderate in duration and have limited involvement with other child-serving agencies. The average duration of system involvement is approximately 3 months, with a minimum of 6–12 visits for assessment, counseling, therapy, or medication management. Families access these services directly by self-referral or referral from another child-serving agency to one of three historic mental health providers.

Targeted mental health services are those that go beyond basic clinic-based therapeutic intervention. Children and families in this category need more intensive services with greater flexibility in the time and location of services provided. These services tend to be community based and family focused and can only be accessed through the Mobile Crisis Assignment Team (MCAT). Assistance at this level of intervention may include universal services as well as case management, therapeutic respite, in-home and/or in-school behavioral health support, day treatment, and home- and community-based treatment. Preauthorization for these services is required by a care manager at one of the mental health providers and can be accessed again by self-referral, by agency referral, or following a crisis intervention by the MCAT.

Intensive mental health services, as implied, are designed for children and their families who have experienced a recent inpatient psychiatric treatment and who require high intensity and lengthy service duration. These children have the greatest risk of out-of-community placement, have severe behavioral disturbance with moderate to severe functional impairment, and typically are involved with one or more child-serving agencies such as juvenile justice, child welfare, substance abuse, and the schools. Intensive services must also come through a referral and recommendation from MCAT and require a wraparound approach for more effective resolution of their issues.

Universal services are provided by the three historic mental health service providers in Clark County: Columbia River Mental Health, Children's Center, or the Children's Home Society. In addition to the three above, targeted services are provided by Family Solutions and the Institute for Family Development. The more intensive services are provided solely by Catholic Community Services.

Wraparound Projects

Following the assignment of intensity level, the second important element of the service delivery process is the system agency from which the child is referred: the approach to service planning and the team involved is dictated by which child-serving system referred the child and family and the level of intensity of services needed.

There are currently strengths-based wraparound projects in place within the juvenile justice system, the school system, and, most recently, the Division of Children and Family Services (child welfare in Clark County). A description of each type of program follows:

Connections Project. Connections, a blended funding partnership between the Juvenile Court and CMHI, is a strengths based program for probationary youth with behavioral health issues. Through application of the system-of-care principles, it is designed to deter youth from continued criminal activity once a court-ordered supervision expires. Moderate- and high-risk youth on community supervision will be considered for the program. Probation counselors will make the referral on youth who have a diagnosed behavioral health disorder, have a score of 1 or greater on the Risk Assessment Section 8 Mental Health, and are residents of Clark County.

School-Based Mental Health Programs. There are currently five school-based mental health projects in operation. These projects have blended funds between mental health and the school system to support the community-based, individualized wraparound approach to service delivery. Each team has a Peer Parent Supporter (parent advocate) and either a Family Resource Specialist (care coordinator) or Child Intervention Specialist. The Evergreen school district's Orchards project covers the elementary-level Behavior Disorder Classrooms; the Vancouver School District's Mobile Intervention Team serves children who have Individualized Education Plans (IEPs) and are at risk for placement in a more restrictive setting; the Battleground Project serves two elementary schools for children at risk for out-of-school placement; the 4-Results Mentoring Project meets the needs of children aged 7–17 years in Medicaid mental health who need a relationship with an older adult for social interactive skills; and the STAR project in an elementary school provides a variety of community-based mental health supports.

IV–E Waiver Demonstration Project. Clark County entered into an agreement with the Division of Children and Family Services (DCFS) to blend funds to support services for youth eligible for public mental health services who are at risk for out-of-home placement. Services will be planned and provided according to the concepts of Individualized and Tailored Care using a Child and Family Team structure.

A. Entry into the Service System

Children are referred to CMHI from a variety of different child-serving agencies, including the school system, juvenile justice, mental health and substance abuse providers, child welfare, foster care, and the developmental disabilities administration. Essentially anyone can make a referral into the system of care, including families and other community-based individuals or groups. For children and families not in crisis, the referral call is placed to one of the three historic mental health service providers noted above. If it is determined by mental health intake screening that the child needs targeted or intensive mental health services, then the child and family are referred to MCAT for further evaluation and referral to targeted or intensive services. For the child in acute crisis, there is a 24-hours-a-day, 7-days-per-week Clark County Crisis Line with coverage by mental health professionals. When the family contacts this number, a therapist will speak immediately with the family. If the child is a potential harm to self or others, the family is referred immediately to the MCAT. The MCAT will take one of four steps: contact the family by telephone, make a home visit,

meet the family at location of their choice, or meet the child and family in the emergency room if this is where the child is. Upon evaluation, the child will referred by MCAT to Targeted or Intensive services.

With the redesign of the system, the process from referral to first contact has gone from 2–4 weeks to less than 24 hours in instances in which the family needs targeted or intensive services. Respondents noted that Catholic Community Services will make a crisis contact for intensive services within 1 hour of referral and within 24 hours for children needing targeted services. With both types of interventions, the completion of paperwork and a detailed intake does not occur until the crisis has stabilized, usually within 1–2 weeks from when the first Child and Family Team meeting is held (see Section II.B., Service Planning, below). From the family perspective, the intake process is not cumbersome at all and, in fact, families are extremely happy with the flexibility and efficiency of the process.

The intake process has been conducted in English, Russian, Spanish, and American Sign Language. Each agency maintains a list of qualified interpreters for translation or interpretation in languages other than English.

B. Service Planning

The service planning process typically is initiated within 1–2 weeks after a child is referred for services. The venue for this process is the Child and Family Team meeting where 100 percent of children and families receive an individualized and tailored plan of care known as a "Family Support Plan" or "Individualized Service Plan." Accountability for this process rests with a "care coordinator" known by different titles such as a school family resource specialist, IV–E Program care coordinator, or Connections Program probation counselor, depending upon the program the child and family are in. The care coordinator's role is to assure that planning, coordination, and implementation of the system-of-care approach are followed. These individuals are, at minimum, bachelor's-level prepared in the social sciences and typically have social work or mental health experience. Another key team member in service planning and provision is the peer parent supporter often referred to as the parent partner. The role of the parent partner is to ensure that there is an advocate for the family, someone to help the family navigate the mental health care system. The parent partner is an individual who either has had or currently has a child with severe emotional disturbance receiving mental health services. Each family is assigned a care coordinator/parent partner team.

The typical care coordinator-to-child ratio varies among each of the programs. Care coordination through Catholic Community Services is the most intense, with the child and family-to-coordinator ratio of 1:5. The school system ratios range between 1:6 and 1:9, the IV–E Program ratios will be a maximum of 1:10, and the Connections Project 1:20. While the Connections Project has a total of four team members for every child and their family, it was noted that this caseload was too overwhelming to coordinate services effectively.

The wraparound service planning process begins with the convening of the wraparound or "wrap" team meeting. The purpose of this meeting is to help the family decide who the service planning

team members should be, to conduct a "strengths chat" with the child and family (and in some cases, other team members), and to develop the individualized and tailored care plan. The development of the plan is one of the strongest components of the wraparound service planning process. Serving as the team facilitator, the care coordinator works with the child and family to elicit needs and strengths across a range of domains, including education, recreation, finance, safety, cultural/religious beliefs, and so forth.

Wrap team meetings are initially held weekly, then move to monthly once the plan is developed. Meeting locations vary depending again on the program involved. They may occur at the school, the home, the Youth House, or the Juvenile Justice Center, for example. Service planning always includes the family, the care coordinator/parent partner team, the child/family therapist, and the relevant agency representative.

Clark County has addressed cultural competence through a variety of mechanisms, including the development of Cultural Competence Standards of Care, a Cultural Competence Committee, RSN community-based training in deaf cultural awareness, and outreach to Hispanic and Russian immigrants. All of these strategies are designed to ensure that mental health providers build on the strengths of those with diverse cultural backgrounds. Evidence of the use of culture in the service planning process pertained mostly to religion and ethnicity.

C. Service Provision and Monitoring

Services are delivered to children and families based upon the results of the strengths chat and the individualized and tailored care plan. Respondents reported that for the most part the service array has adequate capacity and that most of the services in the Family Support Plan are actually provided to and received by children and families. For those services not received, availability and limited transportation (rural areas) were the key barriers identified. While children are able to access services at no costs, parents often have to pay for some services on a sliding scale. For services such as respite and mentoring, wait time was the identified barrier, with waits for services greater than 2 months.

The processes and activities related to the child and families receipt of services is coordinated and monitored through the care coordinator and documented by the relevant service provider in the child's service record. Many different agencies have notations in the record, such as DCFS, probation officers, therapists, respite providers, and family advocates. Wrap team meetings are held on a monthly basis to evaluate the effectiveness of services provided. In addition to these meetings, the care coordinator and parent partners conduct follow-up with families via telephone or in person to assess progress, to do status checks, to ensure that services have been delivered, and, finally, to assess family satisfaction. The frequency of these kinds of follow-up varies from weekly to biweekly to, in some cases, daily, depending upon the nature of the child and family situation.

The times and locations offered for service delivery have improved considerably with the addition of new contract requirements by the RSN that 60 percent of services be provided outside of the agency offices. The addition of Catholic Community Services to the provider network also is noted

as a significant factor in this change. This agency offers flexibility in the times and locations for service delivery with an increase in evening and weekend hours and much faster response time.

Coordination and collaboration processes among service providers, both child-serving and non-child-serving, reportedly have improved across the board (with the exception of children in the care of foster parents). The development of the wraparound team projects is noted as the reason for this. Again with the exception of foster care, the process used to transition children and families to other sites or other service providers is reported to be excellent. Staff communicate well and there is no evidence that children or families fall through the cracks.

In speaking with staff from each of these different wraparound programs, there is evidence that system-of-care principles are being used in service planning and service delivery. There is a wide variation among the mental health service providers, however, in the knowledge level and the degree to which these principles are applied in practice.

D. Case Review

Two committees provide case review services:

The Children's Long-Term Inpatient Program (CLIP). CLIP is a committee made up of representatives from Behavioral Health Services, the Division of Children and Family Services, and other community agencies to expeditiously review cases involving children being considered for long-term inpatient psychiatric treatment. Its tasks include determining whether less restrictive, community-based services are appropriate and developing interim and long-term strategies for supporting children in these least restrictive settings. This committee meets as needed and reports to the System of Care Policy Council on a quarterly basis.

The Community Partners Committee. The Community Partners Committee consists of representatives from child-serving agencies as well as two family representatives. The committee is available to assist children and families to access community programs and services, to identify resource gaps, to assist in developing services to assure least restrictive placement, and to ensure individualized, strengths-based service planning. This committee meets two times per month.

IV. System of Care Strengths and Challenges

The following section outlines CMHI's strengths and challenges as related to infrastructure and service delivery. The term *challenges* is used in a broad sense to identify areas in which the program has not yet made any efforts, or is still in the early stages of development, as well as areas that have been difficult to implement, or in which system-of-care principles have not been successfully achieved.

A. Family Focused

Strengths at the Infrastructure Level

< CMHI has done an excellent job of creating a structure that supports and encourages family involvement at the highest levels of governance. Family representation is evident at all levels of governance, including the System of Care Policy Council's Board of Trustees and Board of Directors, and its subcommittees. According to respondents, family members are respected and their input is valued. This is evidenced by the manner in which CMHI responded to family concerns that the roles of the two different boards were confusing: by merging the boards into one unified System of Care Policy Council. A new Family Services Committee of the council has been created to serve as the central conduit for inclusion of family voice in governance decisions.

< A noted challenge at the first assessment, efforts to encourage family participation in governance meetings have improved. For example, the location of the monthly System of Care Policy Council meeting was changed to a school. This was identified by families as more convenient than the previous location. Mechanisms also have been put in place that facilitate family participation in meetings. These include childcare, food at the meeting, and stipends for transportation.

< During the past 18 months, training sessions for families and child-serving agencies have included Surviving the System, Core Parent Partner Training, Individualized Education Plan, Engaging Diverse Youth and Families in Social Services, Wraparound, and Consultation.

< Family members, and other people from the community have been trained to provide paraprofessional services such as parent partnering, mentoring, and respite care. There is a parent partner role present in every wraparound Child and Family Team meeting, and a pool of parent partners is being developed though the RSN.

< Family involvement in program operations is also significant, including participation in recruiting and hiring of staff, coordinating and training of providers and families, developing and reviewing requests for proposal, serving on a grant oversight committee, and interviewing and serving as team members.

< Family involvement is also evident in quality monitoring. Parents work full-time at Portland State University (PSU) as an integral part of their evaluation team. Family members stationed at PSU participate in the development of survey instruments, data collection and analysis, and the coordination of interviews. One family member has participated in presentations on findings, locally and nationally.

< Information from experience surveys and outcomes data is used to identify service barriers as a means to improve services. A survey showing that client satisfaction was lowest on traditional services led to the development of an RFP designed to expand provider groups. The need for additional childcare and respite services was also identified and brought to the attention of System of Care Policy Council. As a result, access to those services has been improved.

Strengths at the Service Delivery Level

< According to respondents, entry into CMHI is efficient, family friendly, and not at all cumbersome. Families are contacted within 1 hour for crisis care and within 1–2 days of referral for other less intense services to schedule the first Child and Family Team meeting.

< The service planning process emphasizes family involvement throughout. No planning meetings are held without family representation. Family members are treated with respect, encouraged to take an active role in the development of service plans and subsequent evaluations, and to bring support persons to meetings with them. Strengths and needs are assessed for the family and are incorporated into service plans. Documentation in case records is excellent.

< Service providers are attuned to utilizing family strengths and many examples of the successful incorporation of strengths into services were reported. Families are kept informed on their child's progress and are encouraged to express their opinions and suggestions. Family activities are often planned, and financial assistance, discounts, or tickets are provided to support these activities in many cases.

< Service plans are monitored aggressively, and services documented on the plan usually are provided.

< Two committees are in place to provide families, community professionals, and providers with consultation on difficult cases. CLIP is available to screen applications for children being considered for long-term inpatient psychiatric treatment. The Community Partners Group can assist children and families in identifying and accessing community resources. Although it has not yet heard a large number of cases, it meets regularly and is a rich resource of knowledge of services and providers in the community and their guidelines and regulations. It is designed to be family friendly, with the support of parent partners and a pre-meeting orientation stressing that the family is "in charge" of their child's care.

Remaining Challenges

< The manner in which foster parents are included in decisions affecting the child reportedly is poor. Foster parents do not feel respected, valued, or communicated with as much as they would like. Much of this concern is a factor of confidentiality requirements and the way the

child welfare system protects the rights of the biological parents. Foster parents are overly concerned about the need for information, especially when a child is in crisis, i.e., suicidal. The foster parents bear the responsibility for the child yet feel that their opinions are circumvented.

B. Individualized Care

Strengths at the Infrastructure Level

< The management and operations of the grant fully support the process of individualized care. CMHI has created a Children's Flexible Trust Fund with an allocation of $200,000. "Best practice" standards for the wraparound process have been developed, including multi-agency participation in flexible funding and a process for quick payment. CMHI has significantly improved its involvement of youth in the planning and provision of services. The kick-off of the Youth House in December 2001 created a forum for the youth voice in the system of care.

< Extensive staff training in the concepts of individualized care has been provided, including presentations by a nationally recognized expert on wraparound.

< Most respondents indicated that CMHI's service array includes all grant-required services plus residential treatment, inpatient hospitalization, mentoring, drug and alcohol treatment, parent advocacy, transportation, and flexible funding for financial assistance. However, some did not know whether services such as intensive day treatment or intensive home-based treatment, transition-to-adult, and neurological assessment are available.

< There are many mechanisms in place to monitor the effectiveness of services and child outcomes, including the Behavioral and Emotional Rating Scale (BERS), the Child and Adolescent Functional Assessment Scale (CAFAS), and the Child Behavioral Checklist (CBCL). There is also a community-based delinquency survey that measures children's problems in the community, such as truancy and living arrangements.

Strengths at the Service Delivery Level

< Individualized Family Support Plans (FSPs) are developed for 100 percent of children and families. Respondents agree that children must be actively engaged in the process, as much as they are able.

< Children are encouraged to participate in identifying their strengths and needs, in choosing services and providers, and in identifying individuals to accompany them to meetings for support. Many children also have mentors.

< Identifying children's strengths and incorporating them in their FSPs is an expected role of care coordinators. The wraparound service planning process is creative in the way it elicits responses from children. Even though this varies from care coordinator to care coordinator,

in general the process offers the youth the opportunity to be a part of the process. For example, a child might be asked, "If we could make your life perfect, what would we need to do?" or "Why do you think you're cool?" This question is a covert way of encouraging the child to identify his or her strengths. For families, a question might be, "If you weren't having to focus on your child's issues, what would you be doing?" Many examples of how strengths were utilized in the planning of services were cited. One child likes younger children, so arrangements were made for her to work with a foster child at a horse ranch. Another likes to help people, so he was taken to a nursing home and a shelter to assist residents.

< The case records reviewed from Catholic Community Services provided a superb example of how a Child and Family Team process is individualized. Within the record, there are links of the life domain assessed with the overall treatment goal, what is needed to accomplish the goal, the action or strategy and its correlation to the strength, the person accountable, and the timeframe and an update on the progress of the action. Records indicated that there is also diversity in times and meeting locations for service planning and provision.

< Children nearly always receive the services included in their plans. Monitoring, a primary responsibility of care coordinators, is accomplished effectively through frequent contacts with families via telephone and written communications with involved agencies and providers, and at Child and Family Team meetings. Most, but not all, respondents reported that services planned for their children met their needs particularly well.

Remaining Challenges

< Some problems have been identified through the evaluation/quality monitoring process, for example, the fact that many children having major difficulties in school were not receiving mental health services at the school. This has been brought to the attention of the schools and CMHI. There are not yet any reports that changes have been made in response to problems identified, or that follow-up has been performed to find whether the problems persist or have been alleviated.

< Involvement of children in case review, either CLIP or the Community Partners Group, is limited. Although respondents feel that children should be involved, barriers include children who are in detention, who are disruptive, who do not want to participate, or whose families do not want them present.

< The service array, while comprehensive, does not have sufficient capacity to meet the mentoring and respite needs of children and families in a timely manner.

C. Culturally Competent

Strengths at the Infrastructure Level

< A foundation for creating a culturally competent system of care is rapidly evolving. A Cultural Competence Committee has been established. There are now written Cultural Competence Practice Standards to guide the process. Cultural competence training with national experts has been provided to staff, child-serving agencies, and families. Grant staff have visited the Oregon Health Sciences University's Intercultural Psychiatric Program to look at ways to hire staff who reflect the diversity of the community. This particular program is a community mental health service in Oregon for the Russian, Southeast Asian, Bosnian, and Somalian adult population who suffer from mental illness. A local resource directory is also being developed.

< Despite the fact that 87 percent of the Clark County population is Caucasian, CMHI has been successful in hiring a culturally diverse staff, including Russian, Hispanic, Laotian, Cambodian, African-American, and Native American individuals.

< Few families served by CMHI have had primary languages other than English. However, some staff members are bilingual and a network of interpreters has been identified and is available as needed.

< Mechanisms are in place to assure that the quality monitoring process is culturally competent. Questions have been added to the Satisfaction Questionnaire incorporating facets of cultural competence. Interviews have been conducted in Spanish, Cambodian, and Russian, and some interviewers are African-American. Data are being analyzed to determine whether there are any problems that need to be addressed, but no results have been reported or changes made to improve cultural competence.

Strengths at the Service Delivery Level

< Children and families often are linked to providers of similar culture and some bilingual providers are available, as is a network of translators and interpreters. Although the documentation of assessment and inclusion of culture in the service planning process is often incomplete, providers seem to be attuned to including cultural issues in the provision of service and cited many examples of how they utilized family and child culture in working with them. The Children's Home Society has a Youth Minority Group that serves as a valuable resource for providers.

< The case review bodies are prepared to accommodate families' primary languages.

Remaining Challenges

< There has been limited progress toward achieving cultural diversity on the System of Care Policy Council.

< Due to significant increases in the minority population of Clark County, respondents acknowledged that more needs to be done to assure that the service array is able to meet the cultural needs of the target population. However, some steps have been taken. Stakeholders' meetings with community groups and cultural organizations have been held in the community, and the Cultural Competence Committee addresses this topic. A Native American "elder" has been added as a provider. Also, the Clark County Regional Support Network provides mental health services for the Washington School for the Blind and the Washington School for the Deaf, both of which are located in Clark County but serve the entire State.

< Respondents indicated that more effective outreach needs to be done to reach the growing minority population of Clark County. However, cultural competence standards have been developed by the Cultural Competence Committee and contacts have been made with the Russian, Cambodian, and Native American communities. Also, the entry process has been conducted in Russian and in sign language, and mechanisms are in place to conduct the process in other languages, as needed.

< The assessment of culture in the service planning process is minimal, usually including only the classification of race, ethnicity, and religion. Few examples of how culture has been included in the planning of services were cited by respondents or documented in case records.

D. Interagency

Strengths at the Infrastructure Level

< Clark County child-serving agencies actively participating in the System of Care Policy Council include mental health, juvenile justice, child welfare, and education. Some respondents suggested that public health should be involved, and that the schools should be more actively involved. All agencies executed memoranda of understanding at the inception of CMHI to facilitate their participation. New State legislation also requires the collaboration and participation of these public agencies when demonstration projects on systems change are implemented.

< The child welfare, juvenile justice, and mental agencies participate in blended funding arrangements.

< The service array includes services provided by juvenile justice, mental health, education, and child welfare.

Strengths at the Service Delivery Level

< The core child-serving agencies routinely participate in service planning; however, schools are sometimes unable to do so due to scheduling conflicts.

< All child-serving agencies are involved in the case review process for both CLIP and the Community Partners Group and most have referred cases for review.

Remaining Challenges

< Shared administrative activities among the child-serving agencies include jointly developing staff training materials, participating in recruiting and hiring, and occasionally holding joint staff meetings. However, the development of other shared administrative activities such as an integrated management information system (MIS) has not progressed.

< Staff from all child-serving agencies, except health, regularly participate in training sessions. Grant staff are outstationed at the juvenile detention center, schools, and Youth House. However, respondents feel that there is much more to be done to facilitate agencies working together.

< All child-serving agencies, except health, participate in the quality monitoring process to some degree. All provide data, and juvenile justice, child welfare, and mental health serve on the Quality Monitoring Committee. However, the evaluation process does not provide for an assessment of interagency involvement in the system of care and service delivery.

< The creation of Connections and IV–E has temporarily diffused the integration of "all" child-serving agencies being at the table with respect to service delivery. This is less of an issue at the senior administrative level of governance where all agencies participate. It was noted that DCS will need to ensure that the Connections and the IV–E staff at the service delivery level have opportunities to share notes and ensure that there is not duplication of efforts until such time that one streamlined care coordination process across all agencies is in place. All public agencies refer clients to CMHI, but do not assume an active role in the intake process since referrals are channeled through contracted mental health agencies.

E. Collaborative/Coordinated

Strengths at the Infrastructure Level

< Interagency training sessions, quarterly newsletters, press releases, and a Web site have been effective in communicating information concerning the grant to agency staff and providers. Also, Policy Council members are conduits for the dissemination of information within their agencies.

< The coordination of services across providers, agencies, and organizations is the responsibility of care coordinators. Participation in Child and Family Team meetings also assists in breaking down barriers and forming alliances that can result in improved services for children and families. Some respondents cited the need for better participation by schools.

Strengths at the Service Delivery Level

< Outreach efforts to inform other agencies, providers, and organizations about the grant and its services have been substantial and largely successful. Since the first assessment in 2000, CMHI staff have addressed over 2,000 people in public forums. More program awareness, better understanding, and more referrals have resulted.

< Although there is room for improvement, respondents reported that agencies and providers work collaboratively in the service planning and delivery processes, and that participation continues to improve.

< Mental health, juvenile justice, education, and child welfare each provide some of the services in the service array. Care coordination is provided by care coordinators, and parent advocacy is readily available.

< When transitions are made in services or providers, joint efforts serve to ease the process.

< CLIP and the Community Partners Group both have effective methods in place to exchange information and to keep participants informed.

Remaining Challenges

< The quality monitoring process has no mechanism to assess how well services are coordinated and thus cannot be used as a tool to improve service delivery.

< Although any external provider or organization (not agency based) involved in a child's care could refer a case for review, neither case review body has received such a request.

F. Accessible

Strengths at the Infrastructure Level

< CMHI has succeeded in eliminating financial barriers to accessing both traditional and nontraditional services. Uninsured and privately insured children can be eligible for CMHI, but most are covered by Medicaid, which covers the majority of services. County and grant funds cover the rest, including services that most insurers do not cover. Co-payments and sliding-scale fees apply in some cases, but there were no reports of denial of services for financial reasons. The only caveat is that not everyone may be aware of the assistance available for wraparound services or how to access flexible funding.

- Respondents consistently reported that CMHI has responded effectively to identified inadequacies in the service array. For example, a crisis stabilization unit was established in 2000 and since that time no child has been placed in residential care.

- Most providers have flexible hours and convenient locations available to accommodate family needs. Many services are provided in the home. All families have crisis plans in place so they know whom to contact any time of day or night and how to contact them.

Strengths at the Service Delivery Level

- Although there is an acknowledged need for additional outreach to assure that the target population is aware of CMHI, entry into the program is uniformly reported to be easy for families. The time between referral and first service contact has improved substantially. Families are contacted within 60 minutes to 24 hours on most occasions. The first service planning meeting takes place within a week, and the first team meeting is scheduled at that time.

- Service planning meetings are held at times and locations that are convenient for families, often during the evening to accommodate working families. As long as adequate space and privacy can be provided, families select the location and transportation can be arranged. Meetings are held at the office only if that is the family's preference because of convenience and the availability of suitable conference rooms. Although participation in planning meetings is reported to be good, it is a challenge to find times that are convenient for all parties.

- Respondents reported that most services in the service array have sufficient capacity and can be accessed without unreasonable delays. However, concerns were expressed about the adequacy of some services, particularly respite care and therapeutic foster care.

- Care coordinators work flexible hours and often can be reached by telephone or pager. When they are unavailable, someone can always be reached in accordance with the family's crisis plan. They meet with families at any suitable location that the family prefers.

- Transportation assistance is available to families. This includes bus passes, although the public transportation system is reported to be inadequate, money for gas, rides by staff or paraprofessionals, and financial assistance with car repairs.

- There were no reports of financial barriers to accessing services.

Remaining Challenges

- Except for complaints that may be identified through the client satisfaction surveys, there is no mechanism to examine accessibility of services or what may be needed to improve service delivery.

< Both case review bodies hold meetings at set times and locations, although they express willingness to exercise some flexibility to accommodate families.

G. Community Based and Least Restrictive

Strengths at the Infrastructure Level

< All services in the service array are available within Clark County; however there were for some concerns about therapeutic foster care and certain residential facilities.

< The quality monitoring program tracks children served outside of the community through use of the "restrictiveness of living environment" scale, and can be used as a vehicle for improvement. Data show a marked decrease in the number of children placed outside of Clark County.

Strengths at the Service Delivery Level

< Procedures are in place to bring all parties together to exhaust less restrictive options before more restrictive placement are made, and to transition children being served in overly restrictive settings. A concern was expressed that some restrictive placements are necessary for safety of the child.

Remaining Challenges

< Much progress reportedly has been made toward eliminating the occurrence of children being served in settings more restrictive than necessary. Training sessions have been held and services and participating providers expanded in order to make adequate options readily available. However, concerns exist that children are being placed in overly restrictive settings unnecessarily, although new initiatives such as Connections and the IV–E program are expected to address those concerns.

< There is a recognized need for additional therapeutic foster care providers in Clark County, the lack of which requires some children to leave the community. Also, some respondents reported that children have had to leave the community for inpatient care because of the lack of temporary "crisis beds." However, CMHI recently has contracted with a local agency for temporary crisis beds, which is expected to alleviate the problem.

< The quality monitoring program has no system in place to accurately identify and analyze situations in which children are served in settings more restrictive than necessary. The system does measure "functioning vs. services received," which may identify problems and be used for improvement.

V. Sustainability and Lessons Learned

Through its Children's Mental Health Initiative (CMHI), the Clark County Department of Community Services (DCS) has created a vision for implementing and sustaining a community of care for children and families who need mental health services. Strategically, this movement is founded on the principles of a "system of care" for children and their families that is achieved through financial and philosophical partnerships among child-serving agencies; that is driven by the needs, strengths, and culture of the child and family; and that ensures access to services and supports within the community and without limitations of cost, time, or service delivery locations.

< During the past 18 months there has been considerable redesign of both the infrastructure and the service delivery components of CMHI. These activities, as outlined below, have been set in motion to facilitate this reform effort and to promote a fundamental shift in the way mental health services are provided.

< The Clark County Regional Support Network (RSN), which has the contract as the State's Prepaid Health Plan, has been moved back under the auspices of the county DCS. The DCS is now incentivizing providers to provide both traditional and nontraditional quality mental health services and supports through performance-based contracts

< The CMHI Board of Directors has been restructured to ensure a wide range of child-serving agency participation and a stronger, more active family voice.

< Blended funding between the RSN and juvenile justice and the Division of Children and Family Services respectively has occurred.

< There has been expansion of the service array and a redesign of the service delivery system to ensure that every child with a mental problem is identified and referred for assessment and treatment not only through the mental health system, but through the schools, child welfare, juvenile courts, and the community at large.

< The development of county-wide Family Resource Centers and the beginnings of a youth advocacy movement is reviving community-based family involvement and providing forums for information exchange between the community and the county administrators.

With the redesign of the system at large, staff and management of the grant recognize that with change comes confusion in roles and responsibilities at all levels. This will require constant communication and information exchange. Families, in particular, must have a clear understanding of the many avenues by which they can access the system, especially with the multiple wraparound programs in place. Service delivery staff within Connections, IV–E, the School-Based Mental Health projects, and each of the mental health serving agencies may need additional guidance in creating a uniform approach to strengths-based assessment and service planning.

Grant administrative staff within DCS discussed the goal of ultimately moving the system toward a One Child–One Plan approach across all child-serving systems. The implementation of the various wraparound projects with only two partners at the table (as is the case with the programs mentioned above) is the first step. It is intended to educate agency providers on system-of-care concepts and to create a foundation for blended funding and an across-the-board shift away from conventional practice to a more accessible, strengths-based, family-focused model. It is recognized, however, that there is a risk to operating these parallel service delivery approaches, and in essence moving the system backwards, if the streamlined vision of One Child–One Plan is not clearly and repeatedly communicated as the far-reaching goal.